North Bay Regional Health Centre

Diagnostic Imaging
Out-Patient CT Scan
Consultation Request
(705) 474-8600, ext. 2839 / 2820

Patient Name:_____

Health Card #:_____

PHONE #: _____

D.O.B: _____ ❑ Male ❑ Female

FAILURE TO COMPLETE THIS REQUISITION IN FULL WILL RESULT IN A DELAY OF BOOKING THE EXAM(S).
Please check ❒ Yes if this patient is currently taking any cytotoxic medications

CLINICAL INFORMATION

❑ Pregnancy
❑ Adverse Reaction to Contrast
❑ Pediatric, provide weight:_____

DIAGNOSIS

AREA TO BE SCANNED

AVAILABLE PREVIOUS ❑ X-RAY ❑ CT ❑ U/S ❑ MRI

Location:_____ Pervious Exam Date:_____

DOES THE PATIENT HAVE ANY OF THE FOLLOWING CONDITIONS/RISKS?

Renal Disease/Chronic Renal Failure	❑ No ❑ Yes	Stroke	❑ No ❑ Yes
Diabetes	❑ No ❑ Yes	Peripheral Vascular Disease	❑ No ❑ Yes
Organ Transplant/Solitary Kidney	❑ No ❑ Yes	Ischemic Heart Disease	❑ No ❑ Yes
60 years of age or older	❑ No ❑ Yes	Chemotherapy for malignancy	❑ No ❑ Yes
Hypertension	❑ No ❑ Yes	Multiple Myeloma	❑ No ❑ Yes

If 'YES' please provide details:

✳✳If you have checked "Yes" to any of the above conditions there is a risk of contrast induced nephropathy. A current **eGFR is required within 3 months** in order to have exam. Please Fax results to (705) 495-7984✳✳

eGFR _____ Date of Blood Test_____

Signature of Ordering Physician: _____ Print Name of Ordering Physician:_____

For non NBRHC physicians: Please include Ordering Physician # for billing purposes to avoid any delays in care #_____

NON-URGENT ❑	**SEMI-URGENT** ❒	**URGENT** ❒
1.5 - 4 Weeks	10 Days	24 hrs- 48 hrs Call CT Dept. ext. 2839

DI use only:

Procedure Code_____ **Tech Initial**_____

Priority Rating: ❑ Emergent/Immediate (24hr) ❑ Inpatient/Urgent (48hr) ❑ Semi-Urgent (10days) ❑ Non-Urgent(4wks)

Date Requested: ❑ Yes ❑ No _____ eGFR required: ❑ Yes ❑ No

Mark as STAT to flag work list: ❑ Yes ❑ No Facility:_____

Appointment Booked Date: _____ **Clerk Initial:** _____

Patient Contact: 1. Date:_____ 2. Date:_____ 3.Date: _____

eGFR CHECK LIST
Computer Note (Date/Initial) : _____ Pt. Notified (Date) :_____

Blood Work Pending (at site) : _____ Lab Attached (Initial) :_____